

071296 NOV 10 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 7 3 2 7 4 4

1. DECEASED NAME (TYPE OR PRINT) Iva L. Berry			2a. DATE OF DEATH MONTH DAY YEAR 10 29 87		2b. HOUR 2:50 PM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 08-17-1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD		
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Denton Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home
13a. STATE MD		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Hollis G. Alkire			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine T. Flagner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-10-0566		17. INFORMANT ADDRESS Mrs. Lucille R. Correa - Cumberland, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multisystem failure of Org</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Atherosclerotic cerebrovascular disease, Diabetes Mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>87</u> to <u>10-29</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>10-29</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>George B. Stoltzfus</u>		DEGREE MD		22c. DATE SIGNED 10-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George B. Stoltzfus		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-31-1987		23c. NAME OF CEMETERY OR CREMATORY Abe Cemetery	
23d. LOCATION CITY OR TOWN Short Gap		COUNTY Mineral		STATE WV	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 02 1987	
		25b. REGISTRAR'S SIGNATURE <u>Davidson-Hendall</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

BP

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071635 NOV 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 3 2 7 4 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clara W. Edel			2a. DATE OF DEATH MONTH DAY YEAR November 6, 1987		2b. HOUR 12:40 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 21, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett County MD.	
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	12b. KIND OF BUSINESS OR INDUSTRY Westinghouse Corp.	
13a. STATE W. Va.		13b. COUNTY Mineral	13c. CITY OR TOWN Keyser	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1280 Terri Street
14. FATHER'S NAME FIRST MIDDLE LAST William T. Westerman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Lockhart		ADDRESS 340 S. Water St. Keyser, W. Va. 26726	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 226-92-8051		17. INFORMANT William C. Edel	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic infected decubitus ulcers</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>old massive CVA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>					
19a. DATE OF OPERATION <u>11/29</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>11/29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)					
22b. SIGNATURE <u>Dr. Mark Domenick</u>		DEGREE MD		22c. DATE SIGNED 11/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Mark Domenick		22e. ADDRESS Garrett County Memorial Hospital Oakland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/09/87	23c. NAME OF CEMETERY OR CREMATORY Greenwood Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Richmond Va.
24. FUNERAL DIRECTOR <u>Harold W. McKenzie</u>		ADDRESS 111 S. Mineral Markwood-McKenzie Funeral Home		25a. DATE REC'D. BY REGISTRAR NOV 12 1987	
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH3 2 7 4 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE OF ESTI- MATED			2c. DATE PRONOUNCED DEAD			2d. HOUR											
Robert Nelson EDGAR			MONTH DAY YEAR 11 8 1987			MONTH DAY YEAR 11 8 1987			MONTH DAY YEAR 11 8 1987			1050h											
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
Male	White	May 10, 1934	53 YRS.			Pennsylvania			USA														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
McHenry			Bumble Bee Road			Stonemason			Construction														
13a. STATE												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		13f. BOX		13g. ZIP CODE	
Md.												Garrett		McHenry		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 174		21541			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
Cecil				Edgar				Mildred				No				214-34-1503				Deloris E. Edgar, See #13 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY:												immediate											
IMMEDIATE CAUSE (a) <u>Gunshot wound of head, massive cerebral trauma</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) <u>self inflicted</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 101.																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?											
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
				P.M. 19																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION															
								STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
22b. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE <u>George Stoltzfus</u>				TITLE (SPECIFY) <u>Deputy</u>				M.D. <u>Deputy</u>				MEDICAL EXAMINER				DATE SIGNED <u>11-8-87</u>							
EXAMINER'S NAME (TYPE OR PRINT) <u>Dr. George Stoltzfus</u>				ADDRESS <u>Friendsville, Maryland 21531</u>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>				23b. DATE <u>11/11/87</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Garrett Co. Mem. Gardens</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Oakland, Garrett, Maryland</u>											
24. FUNERAL DIRECTOR NAME <u>Bradley A. Stewart</u>				ADDRESS <u>Oakland, Maryland 21550</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 16 1987</u>				25b. REGISTRAR'S SIGNATURE <u>John B. Anderson</u>											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW-1, ATTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			DATE ESTI- MATED			2b. HOUR		
Haroldyne Marie Evendole						11 4 19 87			1850 M					
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR					
Female	White	May 22, 1925	62 YRS.			11 4 19 87			1850 M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH		
Canada			USA			WIDOWED			DIVORCED			Garrett MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Friendsville			Route 1, Box 184C			Homemaker			Own Home					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland			Garrett			Friendsville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Route 1, Box 184C 21531		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Harold			Marie			No			117-14-2084			George S. Evendole		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
						Cardiorespiratory Arrest								
						(b) Hypertensive Cardiovascular disease			years					
						(c) Uncontrolled Hypertension			year					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I														
Adult onset diabetes mellitus														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			21d. INJURY OCCURRED			21e. PLACE OF INJURY		
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			HOUR A.M. MONTH DAY YEAR			ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2			P.M.			AT HOME, STREET, FACTORY, FARM, ETC.)		
21f. LOCATION			21g. LOCATION			21h. LOCATION			21i. LOCATION			21j. LOCATION		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21k. LOCATION			21l. LOCATION			21m. LOCATION			21n. LOCATION		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE			TITLE (SPECIFY)			MEDICAL EXAMINER			DATE SIGNED					
George B. Stalderfus			M.D.			Box 67, Friendsville MD			11-4-87					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
George B. Stalderfus			Box 67, Friendsville MD			Cremation			11/5/87			Smithsburg Crematory		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. DATE REC'D. BY REGISTRAR			25d. REGISTRAR'S SIGNATURE		
J. Lynn Newman			11/16/87						11/16/87					
N. ADDRESS			25e. DATE REC'D. BY REGISTRAR			25f. REGISTRAR'S SIGNATURE			25g. DATE REC'D. BY REGISTRAR			25h. REGISTRAR'S SIGNATURE		
Grantsville, MD 21536			11/16/87						11/16/87					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

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072633 NOV 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH7 3 2 7 4 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George Lee Forney			2a. DATE OF DEATH MONTH DAY YEAR November 6, 1987			2b. HOUR 03:10AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 10, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.				
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co. Memorial Hosp Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister		12b. KIND OF BUSINESS OR INDUSTRY Ministry		
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Accident		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1, Box 62 21520		
14. FATHER'S NAME FIRST MIDDLE LAST Lee --- Forney			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha --- Jones			16. SOCIAL SECURITY NO. 198-14-6046				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Mary I. Forney		17. ADDRESS Route 1, Box 62 Accident, MD 21520				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) aortic stenosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 years years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Oct 28, 19 87, to Nov 6, 19 87, that (I) (we) last saw the deceased alive on Nov 5, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Margaret A Kaiser MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Nov 6 '87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAISER					22e. ADDRESS 311 N 4th St 3 Oakland 21550					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/8/87		23c. NAME OF CEMETERY OR CREMATORY Hoyes Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Friendsville, Garrett, MD			
24. FUNERAL DIRECTOR NAME J. Spindler					ADDRESS Grantsville, MD		25a. DATE REC'D. BY REGISTRAR NOV 13 1987		25b. REGISTRAR'S SIGNATURE L. Fisher	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their place, remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the interment, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, a police report or other traumatic event, the medical examiner must be notified at once.

9 55030 100000

072125 NOV 17 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 2 7 4 9

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE ESTI- MATED			2c. DATE PRONOUNCED DEAD			2d. DATE KNOWN OF DEATH			2e. DATE ESTI- MATED			2f. DATE PRONOUNCED DEAD																																						
Cecil Calvert Friend			11-2-1987			11-2-1987			11-2-1987			11-2-1987			11-2-1987			11-2-1987																																						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. IF UNDER 1 YR.			8. IF UNDER 24 HRS.			9. BALTIMORE CITY OR COUNTY OF DEATH																																						
Male			White			Oct. 16, 1927			60 YRS.			MONTHS			DAYS			HOURS			MIN.																																			
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			11. CITIZEN OF WHAT COUNTRY?			12. MARRIED			13. NEVER MARRIED			14. WIDOWED			15. DIVORCED			16. BALTIMORE CITY OR COUNTY OF DEATH																																						
Maryland			USA			X			NEVER MARRIED			WIDOWED			DIVORCED			Garrett County																																						
17. CITY OR TOWN OF DEATH			18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			20. KIND OF BUSINESS OR INDUSTRY			21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			22. STATE			23. COUNTY			24. CITY OR TOWN			25. STREET ADDRESS			26. INSIDE CITY LIMITS?			27. STREET ADDRESS			28. YES			29. NO			30. RT. 4, Box 364			31. 21550														
Oakland			Rt. 3, Box 221, (farm)			Farmer			Farming			Md.			Garrett			Deer Park			YES			NO			Rt. 4, Box 364			21550																										
32. FATHER'S NAME			33. MOTHER'S MAIDEN NAME			34. WAS DECEASED EVER IN U.S. ARMED FORCES?			35. SOCIAL SECURITY NO.			36. INFORMANT			37. ADDRESS			38. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			39. Sudden			40. IMMEDIATE CAUSE (a)			41. Head and neck injuries			42. DUE TO, OR AS A CONSEQUENCE OF			43. (b)			44. DUE TO, OR AS A CONSEQUENCE OF			45. (c)																	
John Henry Friend			Laura Virgie Upole			Yes			Korean Confl.			213-24-6093			Mrs. Lena I. Friend, See #13 above			Sudden			916			Head and neck injuries			DUE TO, OR AS A CONSEQUENCE OF			(b)			DUE TO, OR AS A CONSEQUENCE OF			(c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			21a. EXTERNAL CAUSE WAS			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			22a. I certify that I took charge of the remains described above, held on			22b. Autopsy			22c. Inspection			22d. Inquiry			22e. and in my opinion			22f. death resulted from			22g. Natural causes			22h. Accident			22i. Suicide			22j. Homicide			22k. Undetermined manner					
									YES			NO			Underlying			11:00AM 11-2-1987			Subject struck by pole			22a. I certify that I took charge of the remains described above, held on			Autopsy			Inspection			Inquiry			and in my opinion			death resulted from			Natural causes			Accident			Suicide			Homicide			Undetermined manner		
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			22a. I certify that I took charge of the remains described above, held on			22b. Autopsy			22c. Inspection			22d. Inquiry			22e. and in my opinion			22f. death resulted from			22g. Natural causes			22h. Accident			22i. Suicide			22j. Homicide			22k. Undetermined manner																	
While			farm			Rt. 3, Box 221, Oakland, Garrett County, MD			22a. I certify that I took charge of the remains described above, held on			Autopsy			Inspection			Inquiry			and in my opinion			death resulted from			Natural causes			Accident			Suicide			Homicide			Undetermined manner																	
AT WORK			AT WORK			AT WORK			22a. I certify that I took charge of the remains described above, held on			Autopsy			Inspection			Inquiry			and in my opinion			death resulted from			Natural causes			Accident			Suicide			Homicide			Undetermined manner																	
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			23e. CITY OR TOWN			23f. COUNTY			23g. STATE			24. FUNERAL DIRECTOR			25. ADDRESS			26. DATE RECEIVED BY REGISTRAR			27. REGISTRAR'S SIGNATURE			28. DATE			29. SIGNED			30. 11-3-87																	
burial			11/5/87			Glendale Cemetery			Swanton, Garrett, Maryland			Bradley A. Stewart			Oakland, Maryland			21550			NOV 16 1987			J. R. Rude			11-3-87			11-3-87			11-3-87			11-3-87																				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGE NO. 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

55152 NOV 1951

20% COTTON LIGED



073312

NOV 27 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed in accordance with the instructions on the back, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 3 2 7 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emmett FRIEND			2a. DATE OF DEATH MONTH DAY YEAR November 13, 1987		2b. HOUR 1:40P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 20, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett County, MD.	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Bus Driver		12b. KIND OF BUSINESS OR INDUSTRY Garr. Co. Bd. of Edu.	
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Friendsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Leslie Edward Friend		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Bell Glotfelty		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-34-1620	
17. INFORMANT ADDRESS 5814 89th Avenue		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month		17. INFORMANT ADDRESS 5814 89th Avenue	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Senile dementia</u>							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>87</u> , to <u>November 13, 87</u> , that (I) (we) last saw the deceased alive on <u>November 13, 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.		22a. SIGNATURE <u>W. Naumann</u> M.D.	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Walter Naumann M.D.		22c. ADDRESS Accident MD 21520		22d. DATE SIGNED 14 NOV 87		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-17-87		23c. NAME OF CEMETERY OR CREMATORY Steele Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Friendsville, Garrett, MD	
24. FUNERAL DIRECTOR NAME <u>D. Spant</u>		ADDRESS Grantsville, MD		25. DATE REC'D BY REGISTRAR NOV 24 1987		25. REGISTRAR'S SIGNATURE <u>Heardon-Randall</u>	

BP

023315 100511

1 - FOR
67 STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death (certificate) be signed and within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) Jennette Stepheson Garlitz		2a. DATE OF DEATH MONTH DAY YEAR 11 25 87		2b. HOUR 4:55 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 29, 1900	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN	
10. CITY OR TOWN OF DEATH Grantsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Goodwill Mennonite Home		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Lonaconing	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1, Box 89		13f. ZIP CODE 21539	
FATHER'S NAME FIRST MIDDLE LAST James --- Broadwater		MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Orianna --- Ross		15. ADDRESS Route 1, Box 89	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 215-34-4403		17. INFORMANT Mrs. Violet Weimer	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Multi System failure of Age years DUE TO, OR AS A CONSEQUENCE OF (c) years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ---			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Anemia (chronic)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1980 , 19 11-25 , 19 87 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 11-11-87 , 19 87 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE George B. Stoltzfus		DEGREE MD		22c. DATE SIGNED 11-25-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George B. Stoltzfus, MD.		22e. ADDRESS Friendsville, MD 21531			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/28/87		23c. NAME OF CEMETERY OR CREMATORY St. Ann's Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Avilton, Garrett, MD		25a. DATE REC'D. BY REGISTRAR NOV 30 1987			
24. FUNERAL DIRECTOR NAME D. Lynn Farnam		ADDRESS Grantsville, MD 21536		25b. REGISTRAR'S SIGNATURE Julia Dindon-Randall	

10.10.12

10.10.12

072126 NOV 17 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH3 2 7 5 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE OF ESTI- MATED			2c. DATE PRONOUNCED DEAD			2d. HOUR		
Myrtle Alice GRAHAM			10 30 87			10 30 87			8:20 p.m.			8:30 p.m.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		
Female	White	March 14, 1899	88 YRS.			Maryland			USA			<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			9. BALTIMORE CITY OR COUNTY OF DEATH		
Oakland			Garrett County Memorial Hospital			Housewife			Home			Garrett MD		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Md.			Garrett			Oakland			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Star Rt. 2, Box 139 21550		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Walter George Meyers			Lillian Dealvis DeWitt			No			213-16-0102			Frederick J. Graham, See #13 above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:												24 hours		
IMMEDIATE CAUSE (a) Pulmonary Edema, Severe														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
(b) Ischemic Heart Disease												Unknown		
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I														
Fracture of right hip - 10/24/87														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
10/25/87			Fracture of right hip - Replacement of femoral head			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
			2:00 P.M. 10/24 19 87			Fell at home attempting to get out of bed								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION								
			Home			Star Route #2, Box 139, Oakland, Garrett, MD								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED								
Herbert H. Leighton			Deputy			31 Oct 1987								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Herbert H. Leighton, M.D.			Oak @ 5th Sts., Oakland, MD 21550			burial			11/2/87			Oakland Cemetery		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Bradley A. Stewart			oakland, Maryland 21550			NOV 16 1987			Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE NAME, ADDRESS, AND PHONE NUMBER OF THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

155150 NOV 13 83

44114 NOTED 80C

072130 NOV 17 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 2 7 5 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR			
Jack			-----			HARDESTY			11 6 1987			5:50 a.m.			
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) (LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR	
Male	White	Sept. 21, 1935	52 YRS.					11 6 1987			6:30 a.m.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			USA						Garrett MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Oakland			Garrett County Memorial Hospital			Timberman			Lumber						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			21538			
Md.			Garrett		Kitzmiller				Star Route						
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Henry Harrison Hardesty						Anna Garce Uphole									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS									
Yes			Korean			220-30-8489 Mrs. M. Gail Hardesty, See #13 above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>Ventricular Fibrillation</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF												minutes			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												Unknown			
(b) <u>Ischemic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF															
(c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
<u>Hypothermia</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Herbert H. Leighton</u>						TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER						DATE SIGNED 6 Nov 1987			
EXAMINER'S NAME (TYPE OR PRINT) Herbert H. Leighton, M.D.						ADDRESS Oak @ 5th Sts., Oakland, MD 21550									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE							
burial			11/8/87		Deer Park Cemetery			Deer Park, Garrett, Maryland							
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE RECD. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Bradley A. Stewart Oakland, Maryland 21550						NOV 16 1987			<u>John Davidson-Randall</u>						

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

025130 101 12 87

20% COTTON 100% WOOL

WINTER 2000



MADE IN ITALY

072822 NOV 21 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 4 should be filed with the funeral director. Page 5 should be filed with the State Dept. of Health and Mental Hygiene. Page 6 should be filed with the State Dept. of Health and Mental Hygiene. Page 7 should be filed with the State Dept. of Health and Mental Hygiene. Page 8 should be filed with the State Dept. of Health and Mental Hygiene. Page 9 should be filed with the State Dept. of Health and Mental Hygiene. Page 10 should be filed with the State Dept. of Health and Mental Hygiene. Page 11 should be filed with the State Dept. of Health and Mental Hygiene. Page 12 should be filed with the State Dept. of Health and Mental Hygiene. Page 13 should be filed with the State Dept. of Health and Mental Hygiene. Page 14 should be filed with the State Dept. of Health and Mental Hygiene. Page 15 should be filed with the State Dept. of Health and Mental Hygiene. Page 16 should be filed with the State Dept. of Health and Mental Hygiene. Page 17 should be filed with the State Dept. of Health and Mental Hygiene. Page 18 should be filed with the State Dept. of Health and Mental Hygiene. Page 19 should be filed with the State Dept. of Health and Mental Hygiene. Page 20 should be filed with the State Dept. of Health and Mental Hygiene. Page 21 should be filed with the State Dept. of Health and Mental Hygiene. Page 22 should be filed with the State Dept. of Health and Mental Hygiene. Page 23 should be filed with the State Dept. of Health and Mental Hygiene. Page 24 should be filed with the State Dept. of Health and Mental Hygiene. Page 25 should be filed with the State Dept. of Health and Mental Hygiene. Page 26 should be filed with the State Dept. of Health and Mental Hygiene. Page 27 should be filed with the State Dept. of Health and Mental Hygiene. Page 28 should be filed with the State Dept. of Health and Mental Hygiene. Page 29 should be filed with the State Dept. of Health and Mental Hygiene. Page 30 should be filed with the State Dept. of Health and Mental Hygiene. Page 31 should be filed with the State Dept. of Health and Mental Hygiene. Page 32 should be filed with the State Dept. of Health and Mental Hygiene. Page 33 should be filed with the State Dept. of Health and Mental Hygiene. Page 34 should be filed with the State Dept. of Health and Mental Hygiene. Page 35 should be filed with the State Dept. of Health and Mental Hygiene. Page 36 should be filed with the State Dept. of Health and Mental Hygiene. Page 37 should be filed with the State Dept. of Health and Mental Hygiene. Page 38 should be filed with the State Dept. of Health and Mental Hygiene. 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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 3 2 7 5 4			
1. FOR STATE REGISTRAR										REG. NO.			
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ada B. MARQUIS										2a. DATE OF DEATH MONTH DAY YEAR November 18, 1987		2b. HOUR 7:30 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 1, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.							
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dennett Road Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN LaVale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 27 Park Ave. 21502					
14. FATHER'S NAME FIRST MIDDLE LAST Robert Lee Brown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeanette Dailey				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16a. SOCIAL SECURITY NO. 214-05-7337				17. INFORMANT Mrs. Betty Reinhart -Cumberland, Md.				17a. ADDRESS 914 Camden Ave. 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor pulmonale</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 yrs</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>ASHD</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 11, 1987</u> to <u>11/18, 1987</u> , that (I) (we) lost saw the deceased alive on <u>11/14, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Thomas G. Johnson</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/20/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas G. Johnson, M.D.				22e. ADDRESS Fourth St. Oakland, Maryland 21550									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/21/87		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Md.							
24. FUNERAL DIRECTOR NAME <u>Robert H. Durst</u> ADDRESS Durst Funeral Home - Oakland, Maryland 21550				25. DATE REC'D. BY REGISTRAR NOV 23 1987		25b. REGISTRAR'S SIGNATURE <u>Julia T. ...</u>							

BP

072087 NOV 17 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 3 2 7 5 5

1. DECEASED NAME (TYPE OR PRINT) Bertha Ann MASON			2a. DATE OF DEATH MONTH DAY YEAR 11 8 87			2b. HOUR 19 30					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 11, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH GARRETT MD.					
10. CITY OR TOWN OF DEATH Deer Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 4, Box 290				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md.			13b. COUNTY Garrett		13c. CITY OR TOWN Deer Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 4, Box 290 21550		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph --- Kitzmiller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Evelyn Lewis			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 233-80-1586	
17. INFORMANT ADDRESS Mrs. Josephine Harvey, See #13 above											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multi System Failure of age</u> years DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Diabetes Mellitus, Atherosclerosis</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1980</u> , 19 <u>80</u> , to <u>11-8</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>August</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>George Stoltzfus</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11-9-87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. George Stoltzfus, MD			22e. ADDRESS Friendsville, Maryland 21531								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 11/12/87		23c. NAME OF CEMETERY OR CREMATORY Shinnston Masonic Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Shinnston, Harrison, West VA				
24. FUNERAL DIRECTOR NAME Bradley A. Stewart			ADDRESS Oakland, Maryland 21550			25a. DATE REC'D. BY REGISTRAR NOV 16 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



072128 NOV 17 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 2 7 5 6

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			3. MONTH DAY YEAR			2b. HOUR		
Frederick Huffman SNYDER			<input checked="" type="checkbox"/> ESTIMATED			11 7 1987			7:50 a.m.		
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			7d. HOUR		
Male	White	Jan. 29, 1938	49 YRS.	MONTHS	DAYS	11 7 1987			9:20 a.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		USA				Garrett					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Mt. Lake Park		101 A Street				Carpenter		Construction			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Md.		Garrett		Oakland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 5, Box 305-A 21550		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Rex Snyder				Clara Alice Miner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				218-34-4449		Mrs. Minnie M. Snyder, See #13 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma - Brain & Skeletal Bones</u>										6 months	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										Unknown	
(b) <u>Carcinoma of the Lung</u>											
(c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED					
<i>Herbert H. Leighton</i>			Deputy			8 Nov 1987					
EXAMINER'S NAME (TYPE OR PRINT) Herbert H. Leighton, M.D. ADDRESS Oak @ 5th Sts., Oakland, MD 21550											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
burial			11/10/87		Oakland Cemetery			Oakland, Garrett, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REG'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Bradley A. Stewart Oakland, Maryland 21550						NOV 10 1987			<i>John Anderson-Randall</i>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1 AND 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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